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ABSTRACT

There is no doubt that women have more depression than men--both treated and untreated--and that depression affects women in their most productive years, impairing personal satisfaction and ability to fulfill social roles. A review of the various therapeutic approaches to depression shows that there is good evidence that the traditional treatments, both pharmacotherapy and psychotherapy, have value, as well as a combination of both approaches. Self-help groups can be used as a supplement to traditional therapies, and a deeper understanding of non-traditional therapies is warranted. (Author/KA)

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DEPRESSION: A SOCIAL OR A MENTAL HEALTH PROBLEM?

IMPLICATIONS FOR THE HEALTH OF WOMEN

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Alternately there are those who argue that even if depression is a result of an oppressive sexist society, women internalize these conflicts and still need help in dealing with consequence of the internalization.

The purpose of this paper is:

1. To review briefly, the evidence for the efficacy of self help groups--particularly consciousness raising groups which are oriented towards identifying and changing those social conditions which presumably oppress women and contribute to their helplessness and depression.
2. To review research evidence for the efficacy of the traditional psychotherapies.
3. To describe the impact of depression on the family life and interpersonal relationships of women as this will give clues to the issues in psychotherapy.

WHAT IS DEPRESSION?

Table 1 describes the symptoms of depression which make up the depressive syndrome.

THE EFFICACY OF FEMINIST SELF HELP GROUPS FOR DEPRESSION

Self help groups as an alternate to traditional treatment for dealing with female depression rest partially on the premises that the traditional feminine roles leads to helplessness and that depression is a state of helplessness. Traditional therapies encourage women to adjust to social situations in which they are helpless and which are depressing. We have identified two pathways by which helplessness and depression can occur. By real social inequities, i.e., discrimination against women makes it difficult for them to achieve and leaves them helpless; or by learned helplessness, i.e. women are trained early as part of being female to act helpless, passive, dependent and non-assertive. The treatment for learned helplessness is the development of emotional awareness of the

condition, i.e. "raising one's consciousness."

Raising Consciousness as Therapy (C.R.)

C.R. groups began to sprout during the early 70's, they are concerned with the social roots of women's helplessness. Table 2 shows a comparison between psychotherapy and C.R. groups.

The traditional C.R. group is small, 6-10 members, leaderless, and has the goal of examining each member's social condition, and its ramification in her personal life. Members encourage one another to become aware, challenge and intervene in those conditions which limit their personal freedom and action. The C.R. groups were adopted by persons involved in the women's movement because of dissatisfaction with traditional therapies which some believe encourage women to accept a submissive role.

C.R. groups have some similarities to traditional therapies. There is opening up, sharing of feelings and opinions in a supportive and confidential relationship. Improvement of morale and self-esteem are the overall goals.

However, there are also important differences. The C.R. group is leaderless, emphasizes peer equality, and relates the women's problems to social, economic and political problems of the women's minority status. Most important, the C.R. group starts with the assumption that environmental rather than intrapsychic or interpersonal dynamics play the major role in the person's difficulties. Moreover, the consumers of C.R. groups are not usually seeking therapy.

Women who attend have reported more independence, confidence, higher ambition and general well being. Consciousness-raising groups could be alternative mental health resources for preventing depression in women. They present intriquing possibilities for preventing that portion of depression which may be associated with women's role.

However, only two studies have systematically studied the C.R. groups and neither of these studies examined the efficacy of C.R. groups (5) (6). Both studies found that the majority of respondents were white, upper middle class, educated women. These women were dissatisfied with their personal lives, had experienced significantly more symptoms of depression and anxiety than a normative sample (although they may not necessarily have had the diagnosis of major depressive syndrome). Relief of personal problems was not the major reason women attended C.R. groups. The majority were or had been in psychotherapy and did not see C.R. as an alternate to psychotherapy. They were seeking help for loneliness, non-assertiveness, identity problems, but not for depression. Researchers have concluded that C.R. was a misnomer and that they should more appropriately be labelled support groups. While many women attending C.R. groups may have depressive symptoms, they may not have been clinically depressed. Also, C.R. groups in the research conducted thus far, does not seem to be used as an alternate for traditional psychotherapy. What about the traditional therapies for depression, psychotherapy either alone or in combination with drugs?

EFFICACY OF TRADITIONAL TREATMENTS FOR DEPRESSION

The Efficacy of Psychotherapy Alone

There is considerable clinical testimony about the value of psychotherapy as the sole treatment for depression and it is a treatment that is widely used in practice. However, scientific testing using controlled clinical trials is only quite recent. Table 3 shows the available studies on the efficacy of psychotherapy alone in depression.

Rehm has tested a self control program vs. social skills therapy and a self control program vs. group therapy control and waiting list control groups.

In general, these studies showed that the self control program was the most efficacious in reducing self-reported symptoms of depression. Shaw tested cognitive vs. behavior therapy and against various control groups including an attention-by-rating and a waiting list-no treatment control group. He found that cognitive treatment was the most effective in alleviating symptoms of depression and that modification and the attention groups were better than no treatment. Klein, et al., are testing time limited focused vs. traditional time unlimited psychotherapy for depression. Controls will include minimal contact and waiting list groups.

The Efficacy of Combined Treatments (Drugs and Psychotherapy)

While we are interested, for this discussion, in the efficacy of psychotherapies, it is important to review the evidence for psychotherapy in conjunction with drugs (usually tricyclic antidepressants) since in practice both treatments are employed either separately, alternately, or combined. Although there is good evidence for the efficacy of antidepressants in reducing the symptoms of depression, there has been concern from those involved in women's issues that women may be overmedicated in order to encourage them to adjust to intolerable situations which, in fact, might require social and political change. Therefore, clarity as to what conditions and on what outcomes we can expect the different treatments to be effective may help us to understand their utility. For this discussion we will examine acute and maintenance therapy separately.

Drugs and Psychotherapy for Acute Treatment

The research evidence for the efficacy of psychotherapy for acute treatment of depression, in comparison or combination with drugs, as for psychotherapy alone, is only now coming available. To date, there are only two

completed randomly-assigned treatment trials using psychotherapy and drugs in acutely depressed patients. Table 4 shows current studies on the efficacy of drugs/psychotherapy in acute tratment.

One recently completed study was reported by Rush, Beck and Kovacs. Their study included 41 acutely ill, unipolar depressed outpatients randomly assigned to twice-a-week cognitive therapy, as compared with imipramine up to 250mg/day for 12 weeks. Both treatment groups showed statistically significant decreases in depressive symptomatology. Cognitive therapy resulted in significantly greater improvement than did pharmacotherapy on both self-reported measures of depression and clinical ratings. This important work is being continued in larger samples and will also include a comparison of the effects of combined treatment.

The New Haven-Boston Collaborative Depression Group (Drs. DiMascio, Klerman, Neu, Prusoff, and myself) have completed a sixteen week study of the acute treatment of depression using a four-cell design: individual interpersonal psychotherapy alone; amitriptyline alone; combined treatment; and no planned treatment. This study showed that all treatments were better than no planned treatment. The drugs and psychotherapy were about equal in symptom reduction and prevention of relapse and that the combined treatment were the most efficacious, better than either treatment alone.

Drugs and Psychotherapy for Maintenance Treatment

What about maintenance treatment? By maintenance treatment I mean treatment of recovered patients in an effort to prevent recurrence of illness. By 1967, there was reasonable evidence for the efficacy of antidepressants on symptom reduction in acute depression, and the most pressing questions were how to prevent relapse and enhance social functioning. It was unclear how long patients should be maintained on drugs, and if psychotherapy should

be added. Three independent maintenance trials using both pharmacotherapy and psychotherapy were funded by the Psychopharmacology Research Branch, National Institute of Mental Health. Table 5 shows studies on the efficacy of drugs/psychotherapy as maintenance treatment.

The New Haven-Boston Study examined eight months of maintenance treatment, amitriptyline, placebo/no pill, with and without individual psychotherapy, in 150 partially recovered depressed women.

The Baltimore Study compared sixteen months of maintenance treatment, imipramine, diazepam, and placebo, with or without four months of group therapy, in 149 partially recovered depressed women.

The Philadelphia Study compared three months of amitriptyline or placebo, with or without marital therapy, in 196 married depressed men and women (80% of the sample was female).

In summary, the findings in the three studies showed that maintenance antidepressants, as compared to placebo or to psychotherapy, was most efficacious in preventing relapse and symptom return. Although some recovery of social performance occurred as a result of the reduction of symptoms, medications themselves had only a limited impact on problems in living. The results for maintenance psychotherapies were also similar between studies.

All three studies show a positive effect for psychotherapy, as compared to low contact or to drugs, which was strongest on areas related to problems in living--interpersonal relationships--and which was less strong or absent on the symptoms of depression per se.

Our interpretation of the findings from the three studies is that for depressives there is a strong argument for combination maintenance treatment (drugs and psychotherapy). The effects of both treatments seem to be largely independent, operating on different outcomes, and there were no reported negative interactions.

CLINICAL ISSUES IN DEPRESSION: IMPACT OF DEPRESSION ON THE LIVES OF WOMEN

Depression has a high morbidity and a serious impact on the social and family lives of women. Since psychotherapy has demonstrated its effect in this area, I would like to review some of our findings on the interpersonal relations and family life of depressed women, as this will give clues to the target areas in the psychotherapy of the depressed patient.

I will next summarize some of the research carried out in New Haven to learn more about the impact of depression. For this research, we followed the social adjustment of 40 depressed women over the course of twenty months, and compared them with 40 women of similar social class, place of residence, race, religion, and marital status, who had had no major physical or emotional problems and had never received psychiatric treatment. These women were, in general terms, the patient's normal neighbors.

The Acute Episode

As might be expected, we found that women suffering from an acute depressive episode were considerably impaired in their daily lives (3). Their impairments reached into all aspects of their lives, as wife, mother, worker, and member of the community. The impairments were most marked in work and in the intimate relationships of marriage and parenthood. They were less marked in the less emotionally-charged and distant relationships with friends and the extended family.

Marriages were characterized by friction, poor communication, dependency, and diminished sexual satisfaction. The depressed women felt a lack of affection towards her husband, together with guilt and resentment. Communication was poor, hostility overt, and she was submissive and dependent. Women who worked outside the home showed less impairment in work than did housewives in their housework. There was a suggestion that an outside occupation had a protective effect.

The Recovery

As symptomatic recovery occurred, there was a general tendency for social adjustment to improve considerably. The improvement was, however, slower than that of symptoms. It was most rapid in the first two months and continued more slowly for the next two months. Thereafter, it was more or less static; in some cases it worsened over the next year. Although the improvement was considerable, it was not complete and did not quite reach the levels of normals.

Symptomatic relapse was accompanied by a rapid worsening of social functioning. In particular, the patient's work performance worsened, her dependency and family attachment increased. The trends which were evident during eight months of treatment were confirmed at follow-up, twenty months after the acute episode. On the whole, the patients' social functioning tended to improve a little further. The general level of adjustment was fairly good, but it was not as good as that of the normals. Many patients sought further treatment, and a number of them had a return of depressive symptoms during the year.

When we returned to these same women four years later we found that only a third of them were completely without symptoms of depression. Although in most cases the symptoms were of mild severity, they were accompanied by impairment in social functioning. Thus, four years after a depressive episode, these women were not functioning as well as the normal neighbors.

While most of the impairment seems to be a function of symptom return, the impairment in marriage and close interpersonal relations persisted even when the patients were symptomatically recovered. The persistence of marital problems found in this study suggested that this was an important target area for treatment.

MARITAL DISPUTES AND DEPRESSION

In our current research we have focused on marital disputes as a target area in the psychotherapy of depression. In this research we have found that men and women differ with respect to the temporal phase of the marital conflict at which they seek mental health treatment. Women tend to seek treatment while still engaged in the marital conflict, whereas men come for treatment after the relationship has been dissolved by separation or divorce.

For the women, depressive symptoms represent an acknowledgement of frustration, failure, hopelessness, and despair reflective of her relative helplessness, dissatisfaction and unmet emotional needs. Men, however, tend to become depressed after the marital relationship has been dissolved when they become aware of the sense of emptiness, loss, and frustration of their nurturance, sexual, affectional, and narcissistic needs.

Based upon this analysis of the relationship between depressive symptoms and the interpersonal context, we have devised a psychotherapeutic approach which attempts to facilitate the resolution of marital disputes.* The psychotherapy involves three components. During the first component, the assessment phase, the psychotherapist evaluates the various role relationships within the marriage and assesses the sources of conflict, disparate definitions and expectations, and the temporal relationship of symptoms to attempts at renegotiation. During the second phase, the psychotherapy aims at facilitating the expression of multiple feelings and states including sadness, guilt, frustration, anger, lust and hopelessness based on the view that the depressive syndrome is a medley of multiple affects, some of which are unacceptable and difficult to acknowledge. During the third component, the patient is assisted in negotiating the resolution of the

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*The concept of psychotherapy as resolution of disputes was initially suggested to the author by Gary Jacobson, M.D. in an unpublished paper presented to the Senior Staff at the M.G.H. Psychiatry Department, 1975.

dispute by clarification of her wishes, needs, interests, as distinct from cultural expectations and stereotypes. During this phase of treatment, elective attempts may be made to relate the patient's current situation to antecedent childhood and familial conditions and also to identify ongoing and enduring personality style which may interfere with the patient's capacity to negotiate to her own best interest. These personality styles may include passivity, low self-esteem, lack of assertiveness, inhibition of guilt, turning of anger against the self, and other mechanisms previously identified as characteristic of women and depression-prone individuals.

Although this psychotherapeutic approach is still in the developmental stage, we have evidence in support of its utility from case reports as well as from our empirical studies, and we will be testing to see if greater emphasis on marital disputes during the course of therapy will have an impact on this enduring problem in the lives of many formerly depressed women.

CONCLUSION

There is no doubt that women have more depression, both treated and untreated and that depression affects women in their most productive years, impairing personal satisfaction and ability to fulfill social roles and that unsatisfying marriages seem to be a major problem in the lives of many depressed women.

There is good evidence that traditional treatments, both pharmacotherapy and psychotherapy, have value. Drugs essentially reduce the acute symptoms of depression and prevent their return and psychotherapy emhances interpersonal satisfaction and adjustment in the major roles. The advantage for combined treatment is striking and represents a possible additive effect of two treatments. The most frequent issues in the psychotherapy of depressed women are the problems in their intimate relationships--usually marriage. There is good evidence that an intimate confiding relationship protects women against depression in the face of life stress. Many depressed women lack that resource.

The concept of self-help for learned helplessness has a certain intuitive appeal. I suspect that C.R. groups, as the sole therapy, probably would not be too helpful and certainly not as rapid as antidepressants for the full blown syndrome of depression. Self-help groups seem to be used as a suppliment and not an alternative to traditional therapies. These groups require more energy, engagement and optimism than someone with a moderate clinical depression can muster. Many women attending these groups may have mild depressive symptoms but few have the full blown depressive syndrome. Moreover, these groups appeal to a limited subsample of women - the educated, white, upper middle class. I would speculate that self-help groups may help prevent more serious symptoms in many dissatisified unhappy and lonely women. They may also be useful as an adjunct to therapy following symptom reduction. Self-help groups are certainly as difficult to evaluate as the traditional psychotherapies, probably even more so since women in the movement share a distrust of behavioral scientists. A deeper understanding of non-traditional therapies such as women's C.R. groups and an evaluation of their role in preventing mental disorders and in providing support and emotional bonds is both timely and warrented.

Depressions for women are both a social and a mental health problem. The research evidence strongly suggests that depressed women can rely on the traditional therapies and that these therapies should include both psychosocial and pharmacologic approaches.

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TABLE 1

SYMPTOMS OF DEPRESSION

Depressed Mood

Changes in Appetite

Disturbed Sleep

Loss of Pleasure

Loss of Energy

Loss of Interest in Work

Decrease in Sexual Interest

Fall in Self-Esteem

Feelings of Helplessness

Anxiety

Feelings of Guilt and Shame

Pessimism and Hopelessness

Bodily Complaints

Thoughts of Death

TABLE 2

COMPARISON OF TRADITIONAL PSYCHOTHERAPIES AND CONSCIOUSNESS-RAISING GROUPS

TRADITIONAL PSYCHOTHERAPIES	CONSCIOUSNESS-RAISING GROUP
Improve morale and self-esteem.	Improve morale and self-esteem.
Confidential relation with therapist.	Confidential relationship with group members.
Supportive relationship.	Supportive relationships.
Power in Therapist.	Power in Group.
Therapist is in charge.	Leaderless.
Problems are related to inner dynamics.	Problems are related to society.
Emphasis on personal problems.	Emphasis on society, economics and politics.
Therapist defines goals.	Group members define goals.
Change the person to adjust to society.	Change members' perceptions and change society.
Talking.	Social action, talking, and listening.
Source of discomfort is internal.	Source of discomfort is in society.
Patient-therapist unequal.	Peer equality.

TABLE 3. THE EFFICACY OF PSYCHOTHERAPY ALONE IN DEPRESSION

TIME (WEEKS)	TREATMENTS	OUTCOME	REFERENCE
6	Self-Control/ Social Skills ——— Self-Control/ Group/W.L.* (N = 24)	Self-Control Better	(7)
4	Cognitive/Behavior/ Attention by Rating/ W.L.* (N = 32)	Cognitive Best	(8)
8	Social Learning/ Dr's Choice (N = 20)	Social Learning Better	(9)
10	Time Limited/ Time Unlimited/ Minimal Contact/ W.L.* (N = 120)	In Process	(10)

*W.L. - Waiting List

TABLE 4. THE EFFICACY OF PSYCHOTHERAPY AND DRUGS IN ACUTE DEPRESSION

TIME (WEEKS)	TREATMENTS	OUTCOME	REFERENCE
12	COGNITIVE/DRUGS (N = 41)	COGNITIVE THERAPY BETTER	(11)
16	INTERPERSONAL PSYCHOTHERAPY/DRUGS/BOTH/NONSCHEDULED CONTROL (N = 86)	COMBINED TREATMENT BEST	(12)
12	SOCIAL SKILLS/DRUGS/BOTH (N = 150)	IN PROCESS	(13)
12	COGNITIVE/DRUGS/BOTH (N = 180)	IN PROCESS	(11)

TABLE 5. THE EFFICACY OF MAINTENANCE PSYCHOTHERAPY AND DRUGS FOR DEPRESSION

TIME IN MONTHS	TREATMENTS	EFFECT OF ANTIDEPRESSANTS	EFFECT OF PSYCHOTHERAPY	REFERENCE
8 8	Amitriptyline/Placebo/ No Pill Individual Psychotherapy (N = 150)	Reduced Relapse. No Effect on Social Functioning.	Improved Social Functioning. No Effect on Relapse.	(14)
16 4	Imipramine/Diazepam/ Placebo Group Therapy (N = 149)	Reduced Relapse.	Improved Empathy. Reduced Sensitivity. No Effect on Relapse.	(15)
3 3	Amitriptyline/Placebo Marital Therapy (N = 196)	Reduced Symptoms. No Effect on Marriage.	Improved Family and Marriage. Slight Symptom Relief.	(16)